Mississippi Medicaid:

Telligen Provider Review Training
Private Duty Nursing (PDN)

August 2025

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Housekeeping

Questions

- Please enter all questions into the chat
- Any unanswered questions will be answered and posted to the website

Survey

- All registrants will be sent a Survey via email following today's training. Telligen welcomes your feedback and suggestions on future training opportunities.

Feedback

- For specific complaints or to provide feedback on the review process, please send your concerns through our Provider Help Desk via Email: msmedicaidum@telligen.com or Toll-Free Phone: 855-625-7709

Purpose of the Presentation

The purpose of this presentation is to:

- **Troubleshoot** authorization submission issues.
- **Enhance Navigation Skills** in Qualitrac platform effectively.
- **Educate Providers** on processes , required documentation and guidelines for Review Request.

Agenda

- Housekeeping Items
- Contact Information
- Review Timing Overview
- Verifying Eligibility
- Entering Physician Information
- InterQual
- RFI, Change Request and Discharge Task
- Appeals & Denials
- Website Tour
- Questions

Contact Us

Education Manager – Primary Point of Contact

Charity A Jones chjones@telligen.com

Book 1 on 1: Book with Charity

Website: https://msmedicaid.telligen.com/

Mississippi Call Center & Provider Help Desk

- Email: msmedicaidum@telligen.com
- Toll-Free Phone: 855-625-7709
- Fax: 800-524-5710

Portal Registration Questions

- Email: qtregistration@telligen.com
- Toll-Free Phone: (833) 610-1057

Program Manager

Claudia Collins

Assistant Program Manager

Cassandra Bullock

Understanding Key Review Terms & Processes

Review Timings

- **Prospective**—Review submitted before services begin, covering future dates
- **Concurrent**—Initial review for services already in progress, covering a date span under one authorization. Concurrent reviews are ongoing admission.
- **Retrospective:** Retroactive authorizations are applicable when there has been a change in coverage, and the patient is determined to be retroactively eligible. The start and discharge/end dates must occur before the request date.

The timing of a review in Qualitrac is determined by when the services are/were provided

Verifying Eligibility

Verifying Eligibility

Why Eligibility Verification Matters

- Confirms active Medicaid coverage for the date of service
- Avoids denials due to eligibility issues
- Provides details on benefit plans, managed care assignments, and limitations

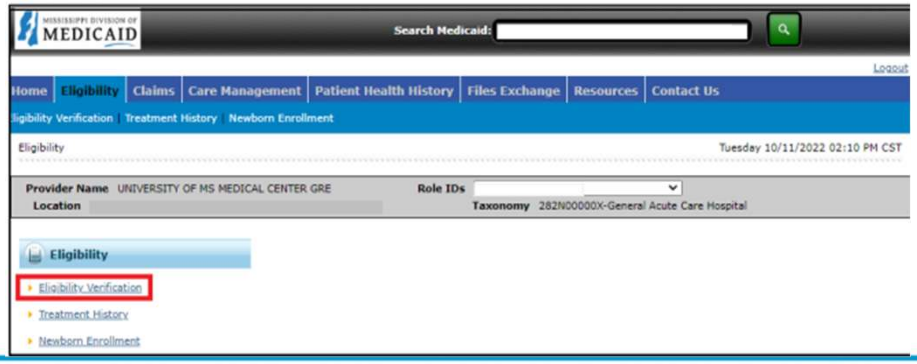
Telligen reviews only beneficiaries enrolled in the TXIX Benefit Plan, except for three specific review types.

- Swingbed services
- ICF-IID
- KBP (formerly DCLH)

Key Takeaways

- Verify eligibility **before** submitting Prior Authorization Request
- Verify eligibility **before** providing services





Verifying Eligibility

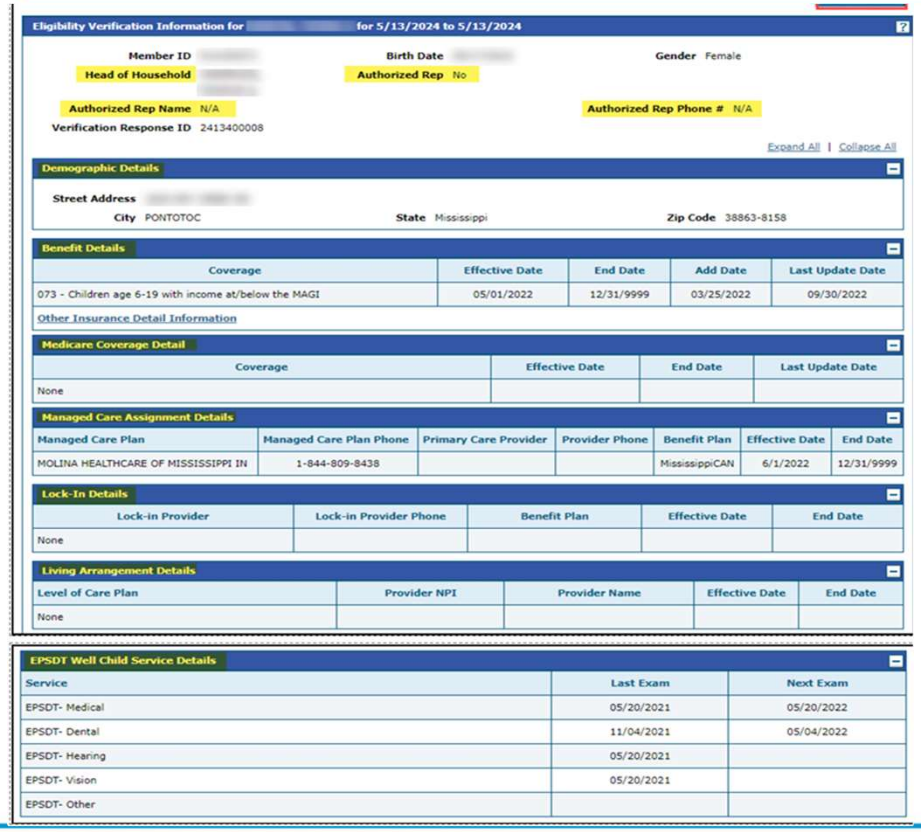
1. Enter the Member ID, or if you don't have it, enter two of the following: SSN• DOB or Member's Full Name
2. Enter the Begin Date and the End Date





Verifying Eligibility

Beneficiary Record Summary



Eligibility Verification Information for [redacted] **for 5/13/2024 to 5/13/2024**

Member ID [redacted] **Birth Date** [redacted] **Gender** Female
Head of Household [redacted] **Authorized Rep** No
Authorized Rep Name N/A **Authorized Rep Phone #** N/A
Verification Response ID 2413400008

Expand All | Collapse All

Demographic Details

Street Address [redacted]
City PONTOTOC **State** Mississippi **Zip Code** 38863-8158

Benefit Details

Coverage	Effective Date	End Date	Add Date	Last Update Date
073 - Children age 6-19 with income at/below the MAGI	05/01/2022	12/31/9999	03/25/2022	09/30/2022

Other Insurance Detail Information

Medicare Coverage Detail

Coverage	Effective Date	End Date	Last Update Date
None			

Managed Care Assignment Details

Managed Care Plan	Managed Care Plan Phone	Primary Care Provider	Provider Phone	Benefit Plan	Effective Date	End Date
MOLINA HEALTHCARE OF MISSISSIPPI IN	1-844-809-8438			MississippiCAN	6/1/2022	12/31/9999

Lock-In Details

Lock-in Provider	Lock-in Provider Phone	Benefit Plan	Effective Date	End Date
None				

Living Arrangement Details

Level of Care Plan	Provider NPI	Provider Name	Effective Date	End Date
None				

EPSDT Well Child Service Details

Service	Last Exam	Next Exam
EPSDT- Medical	05/20/2021	05/20/2022
EPSDT- Dental	11/04/2021	05/04/2022
EPSDT- Hearing	05/20/2021	
EPSDT- Vision	05/20/2021	
EPSDT- Other		

The system returns the eligibility verification for the member including the following: applicable

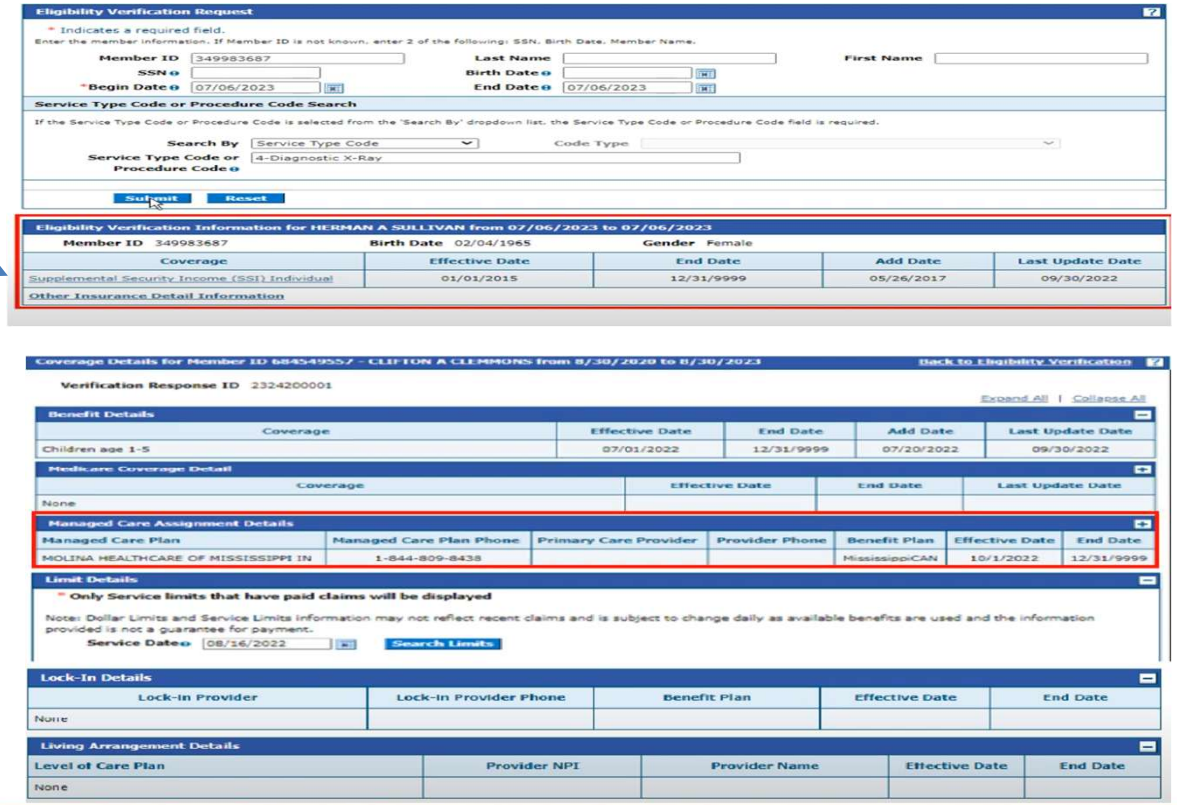
- Head of Household
- Authorized Rep Name
- Authorized Rep Phone #
- Demographic Details,
- Benefit Details
- Managed Care Details
- Lock-In Details
- Living Arrangement Details, and EPSTD details.

Remember, coverage is not a guarantee as a member can lose eligibility for a variety of reasons

Verifying Eligibility

Beneficiary Record Summary

To see more of the benefit plan, click the Medicaid Policy link.



Eligibility Verification Request

* Indicates a required field.

Enter the member information. If Member ID is not known, enter 2 of the following: SSN, Birth Date, Member Name.

Member ID 349983687 | Last Name | First Name

SSN | Birth Date

*Begin Date 07/06/2023 | End Date 07/06/2023

Service Type Code or Procedure Code Search

If the Service Type Code or Procedure Code is selected from the 'Search By' dropdown list, the Service Type Code or Procedure Code field is required.

Search By: Service Type Code | Code Type

Service Type Code or Procedure Code: 4-Diagnostic X-Ray

Submit | Reset

Eligibility Verification Information for HERMAN A SULLIVAN from 07/06/2023 to 07/06/2023

Member ID 349983687 | Birth Date 02/04/1965 | Gender Female

Coverage	Effective Date	End Date	Add Date	Last Update Date
Supplemental Security Income (SSI) Individual	01/01/2015	12/31/9999	05/26/2017	09/30/2022

Other Insurance Detail Information

Coverage Details for Member ID 68454955J - CLIFTON A CLEMMONS from 8/30/2020 to 8/30/2023 — Back to Eligibility Verification

Verification Response ID 2324200001

Expand All | Collapse All

Benefit Details

Coverage	Effective Date	End Date	Add Date	Last Update Date
Children age 1-5	07/01/2022	12/31/9999	07/20/2022	09/30/2022

Medicare Coverage Detail

Coverage	Effective Date	End Date	Last Update Date
None			

Managed Care Assignment Details

Managed Care Plan	Managed Care Plan Phone	Primary Care Provider	Provider Phone	Benefit Plan	Effective Date	End Date
MOLINA HEALTHCARE OF MISSISSIPPI IN	1-844-809-8438			MississippiCAN	10/1/2022	12/31/9999

Limit Details

** Only Service limits that have paid claims will be displayed

Note: Dollar Limits and Service Limits information may not reflect recent claims and is subject to change daily as available benefits are used and the information provided is not a guarantee for payment.

Service Date 08/16/2022 | Search Limits

Lock-In Details

Lock-In Provider	Lock-In Provider Phone	Benefit Plan	Effective Date	End Date
None				

Living Arrangement Details

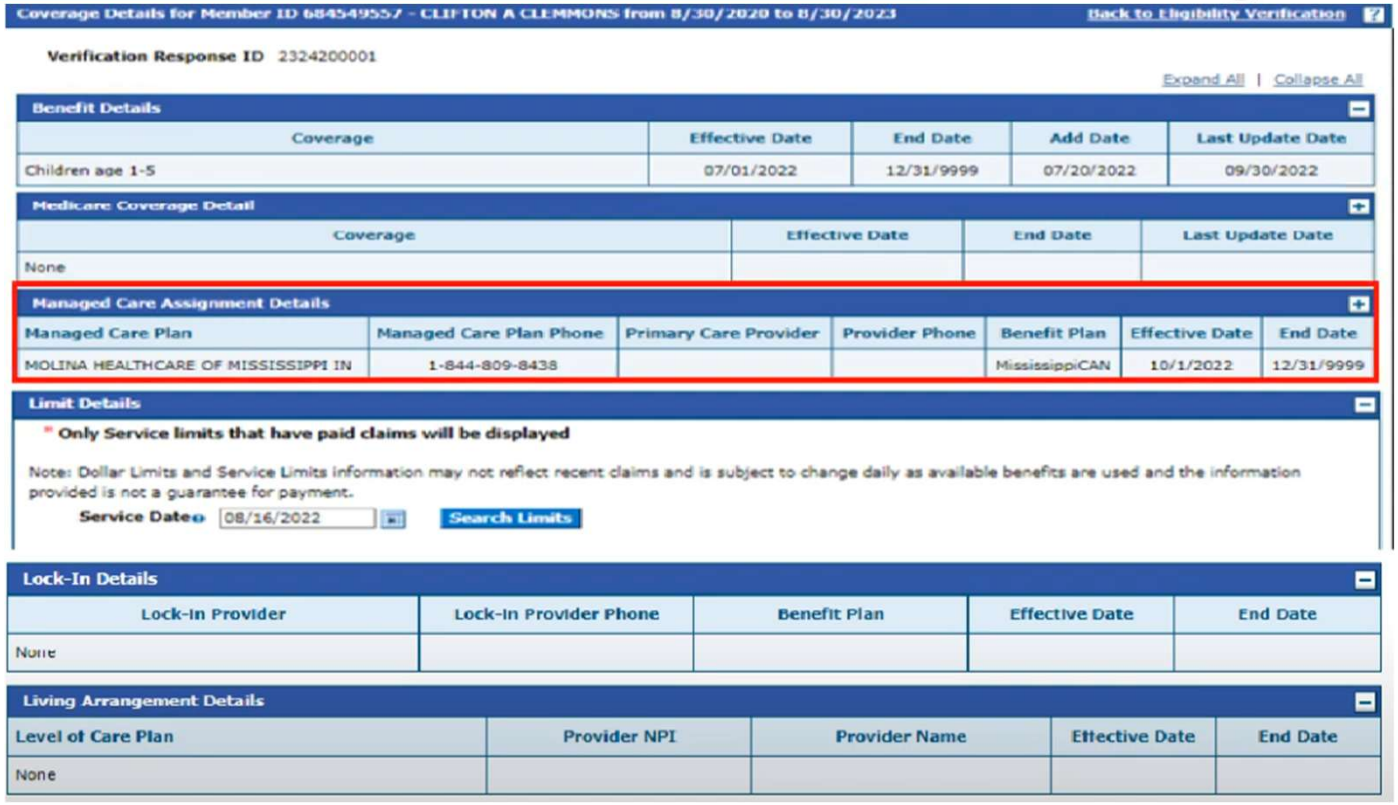
Level of Care Plan	Provider NPI	Provider Name	Effective Date	End Date
None				

Verifying Eligibility

Beneficiary Record Summary

The Benefit Screen

- Benefit Plan
- Medicare Coverage Detail
- Manage Care Details
- Lock In Details & more



Coverage Details for Member ID 684549557 – CLIFTON A CLEMMONS from 8/30/2020 to 8/30/2023 — Back to Eligibility Verification

Verification Response ID 2324200001

Expand All | Collapse All

Benefit Details

Coverage	Effective Date	End Date	Add Date	Last Update Date
Children age 1-5	07/01/2022	12/31/9999	07/20/2022	09/30/2022

Medicare Coverage Detail

Coverage	Effective Date	End Date	Last Update Date
None			

Managed Care Assignment Details

Managed Care Plan	Managed Care Plan Phone	Primary Care Provider	Provider Phone	Benefit Plan	Effective Date	End Date
MOLINA HEALTHCARE OF MISSISSIPPI IN	1-844-809-8438			MississippiCAN	10/1/2022	12/31/9999

Limit Details

** Only Service limits that have paid claims will be displayed

Note: Dollar Limits and Service Limits information may not reflect recent claims and is subject to change daily as available benefits are used and the information provided is not a guarantee for payment.

Service Date 08/16/2022 Search Limits

Lock-In Details

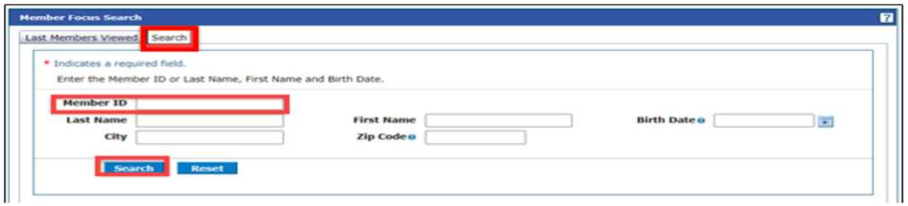
Lock-In Provider	Lock-In Provider Phone	Benefit Plan	Effective Date	End Date
None				

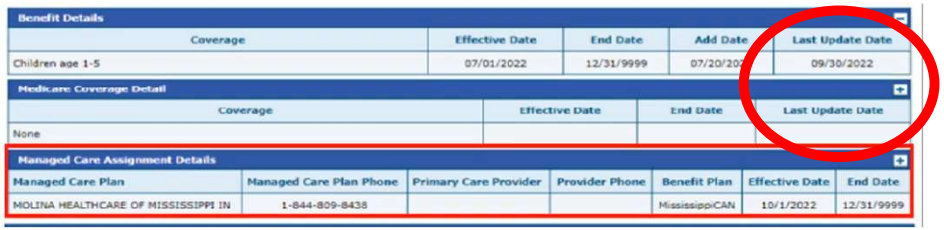
Living Arrangement Details

Level of Care Plan	Provider NPI	Provider Name	Effective Date	End Date
None				

Verifying Retro Eligibility







1. To view Retro Eligibility, log into the portal, and select the Member Focused Viewing Link found at the bottom, left side of the home page.

2. Select the Search Tab, enter the Member ID, and select Search.

3. This shows you the member demographics, the original effective date, and the end date of coverage.

Per Mississippi Medicaid Admin Code Title 23, Part 200, Rule 1.8, claims denied for untimely filing may only be reviewed if the member has retroactive eligibility and prior authorization (if required) was obtained within 90 days of the eligibility add date.

Timely filing depends on whether the date of service is before or after the add date:

Retro Vs. Not Retro Eligible

Date of Service (DOS): 2/4/2025

Benefit Add Date in MESA: 4/2/2025

📌 **Explanation:**

The Date of Service occurred **before** the add date, the patient is **retro eligible**.

The provider now has **90 calendar days from the Add Date** to submit a prior authorization request.

Date of Service (DOS): 6/2/2025

Benefit Add Date in MESA: 3/25/2024

📌 **Explanation:**

The Date of Service occurred after the add date, the patient is **not retro eligible.**

Verifying Physician / Facility Information

Providers Panel: Physician and Provider Information

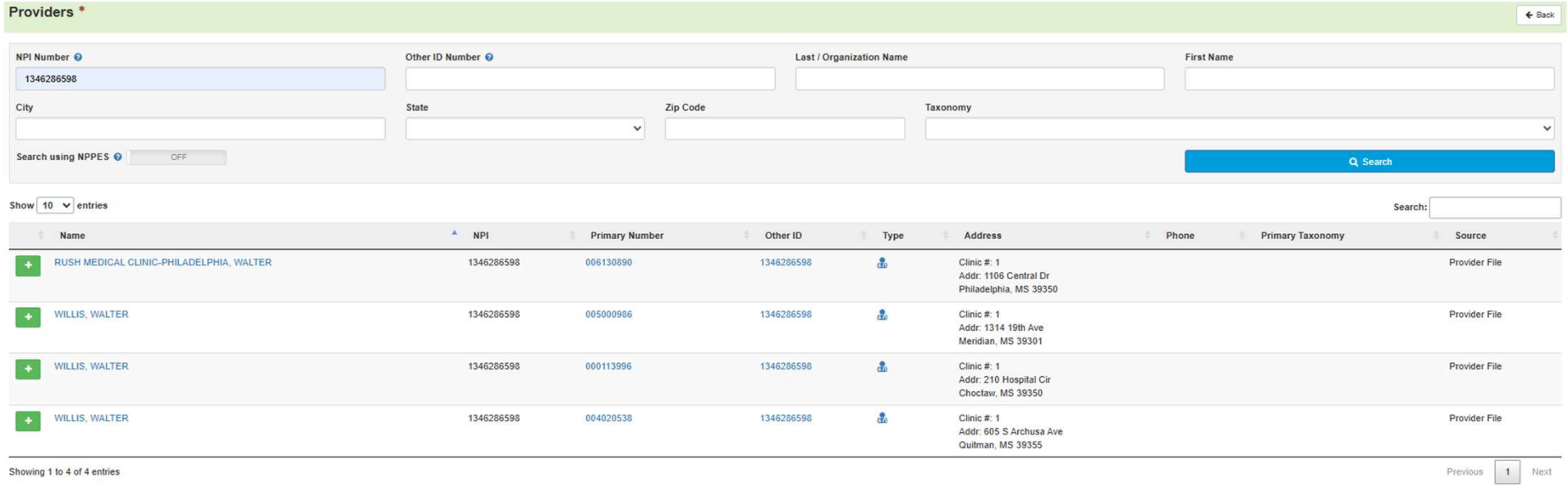
- **Providers:** This section requires information related to who is ordering and providing the care:
  - *Treating Provider – Will always be the* **PDN Company** providing the care
  - *Ordering Provider- Will always be the* **ordering Physician** the care



click the Add button on each box to fill in the necessary provider information

Entering Physician and Facility Information by NPI

- **Clicking** + Add will open a search box. You can search by entering an **NPI number**, Medicaid ID, or by filling in any of the information boxes provided if the NPI is not known.
- Once you have entered the necessary information, click search to locate the physician or facility you are looking for.

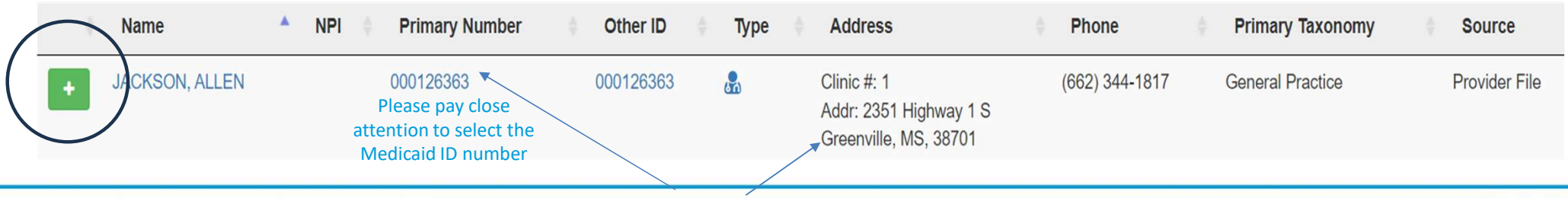


Entering Physician and Facility Information

- Clicking search will return **all** results that meet your entered criteria.
- Click the blue hyperlink in the provider's name to view additional details.
- Check the provider details before selecting, validating the correct provider and the taxonomy ID align to the services being requested

Use the green plus box next to the name to select the provider/facility that you need for the review.

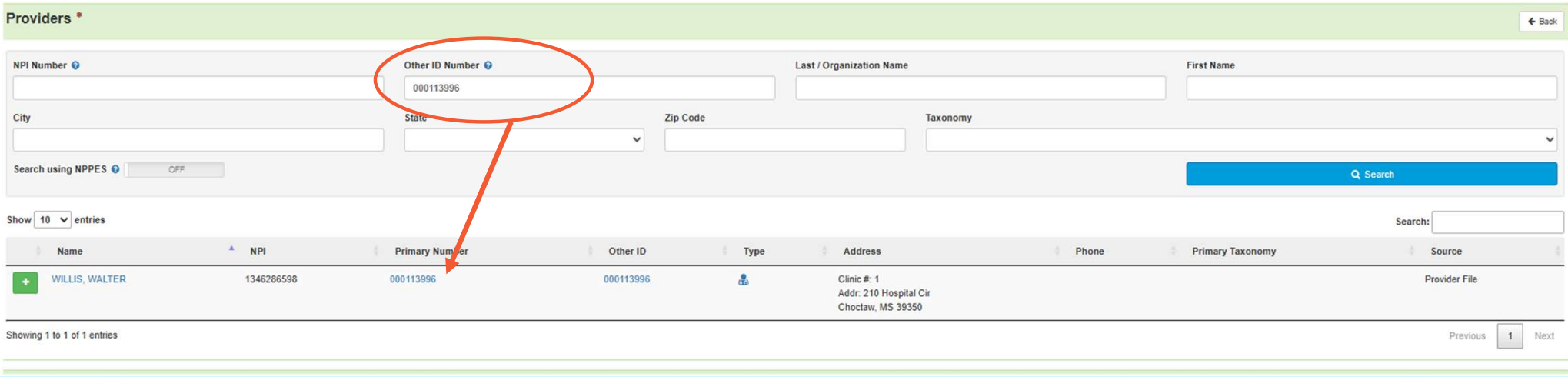




Please pay close attention to the name and location selected. Example: PDN Services LLC vs PDN Services Inc. This is an important point because some providers have multiple locations under the same NPI and possibly similar name.

Entering Physician and Facility Information by Medicaid Provider ID

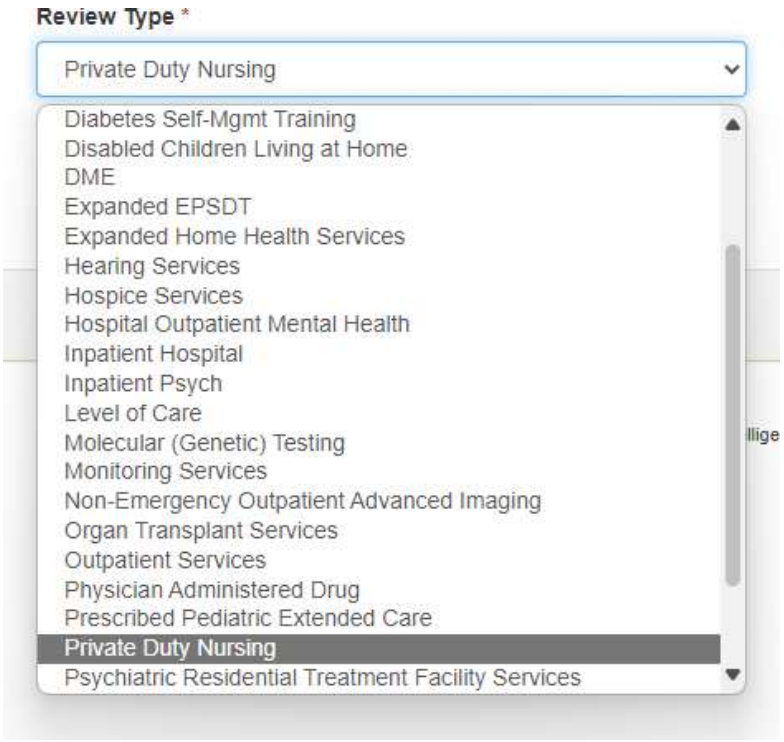
- **Clicking** + Add will open a search box. You can search by entering an NPI number, **Medicaid ID**, or by filling in any of the information boxes provided if the NPI is not known.
- Once you have entered the necessary information, click search to locate the physician or facility you are looking for.



Submitting a Review

Authorization Request Panel- Review Type

- Enter the **Review Type**: This is where you will select the type of review you are requesting.
  - The review appropriate for this is **Private Duty Nursing**



Telligen Provider Portal – Required sections

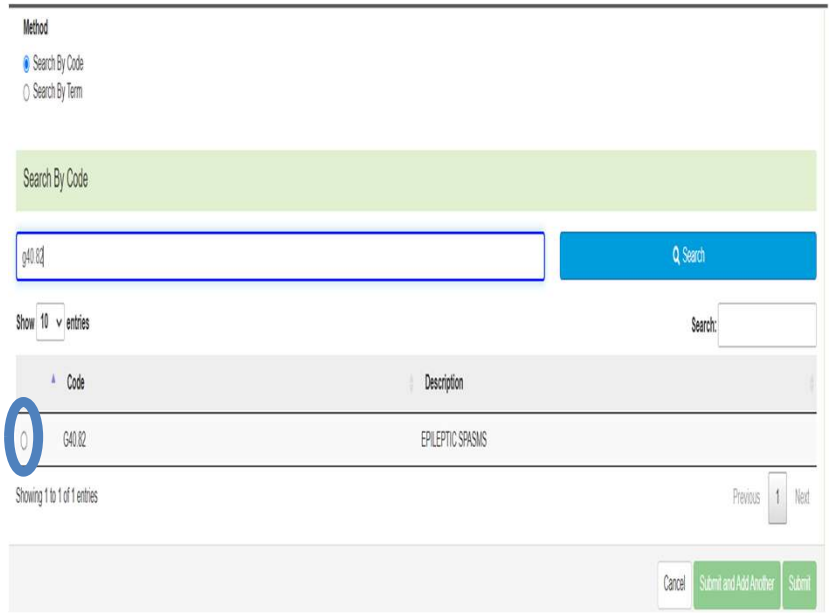
The following panels will be required for your request:

- **Authorization Request Type**
- **Dates of Service**
- **Eligibility Verification**
- **Providers & Provider Organization Visibility**
- **Diagnosis &Procedures**
- **Documentation**
- **InterQual**

Diagnosis, Procedure Codes and Modifiers

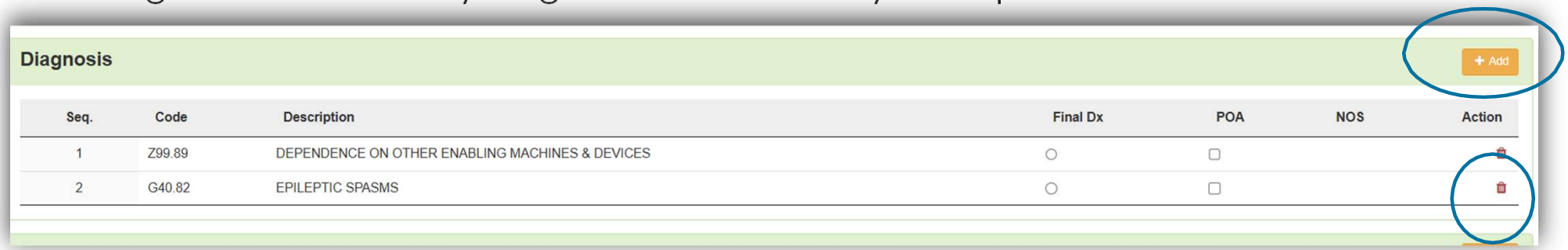
Diagnosis Panel cont.

- Once you click + Add you will have the ability to search for a diagnosis either by Code or by Term.
  - Select method: Code or term to search (radio button to select)
  - Enter information in the search box
  - Click Search
- The system will provide you a list of results you can select from. Select the one that you want added to the review by clicking on the radio button to the left of the code.



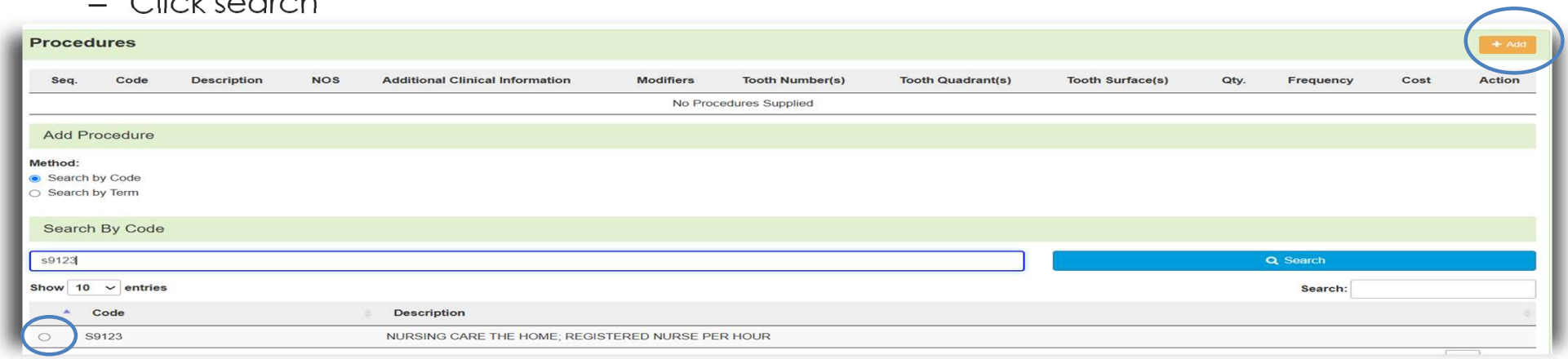
Diagnosis Panel cont.

- After selecting the diagnosis you want added to the review, you can select Submit or Submit and Add Another.
- **Submit** will add the diagnosis to the review.
- **Submit and Add Another** will allow you to submit the diagnosis to the review and re-open the window where you can search for another diagnosis.
- You can use the **trash can** icon on the right side of the diagnosis to delete anything entered incorrectly in this panel.



Procedure(s) Panel

- The **Procedures Panel** is where the procedure code information related to this review is added.
- Click the + Add button to add a new procedure to the panel.
  - Select Radio button to indicate a code or term search
  - Enter information in the search box
  - Click search

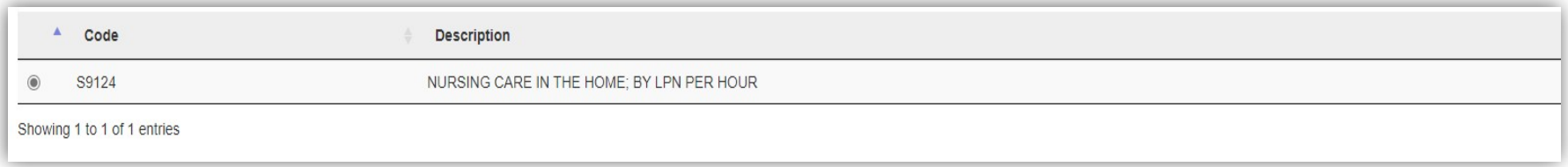


Procedure(s) Panel cont.

- The Term search allows for the user to search based on Section, category and sub-category if needed

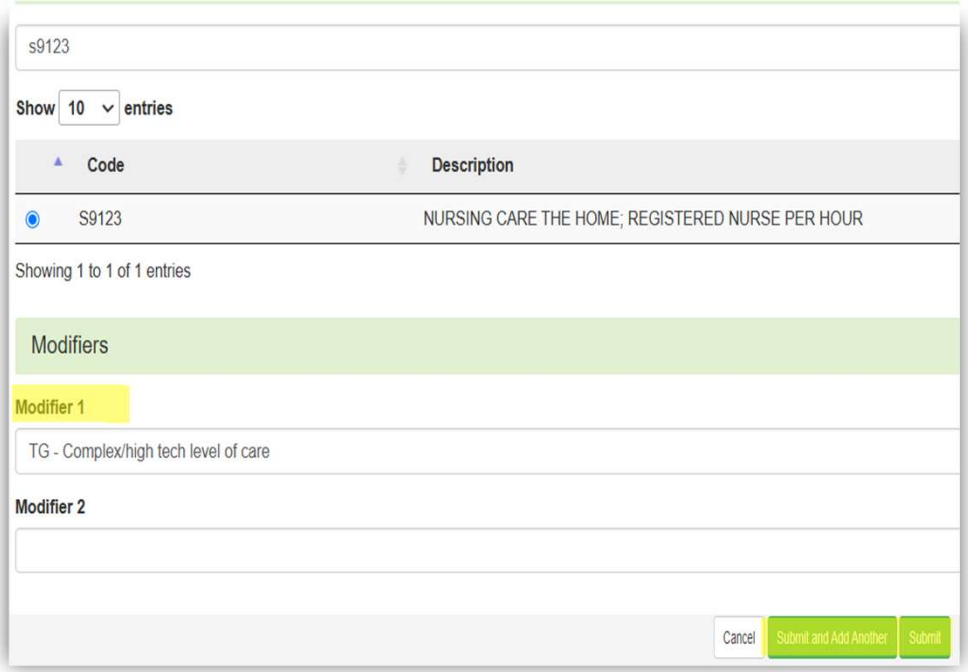


- Once Query has populated, Use the radio button to Select the correct Procedure(s)



Modifiers

Once Query has populated your procedure code, use the radio button to select the correct Procedure(s) then the modifier section will be available to complete the details as needed



After selecting the procedure(s) you want added to the review:

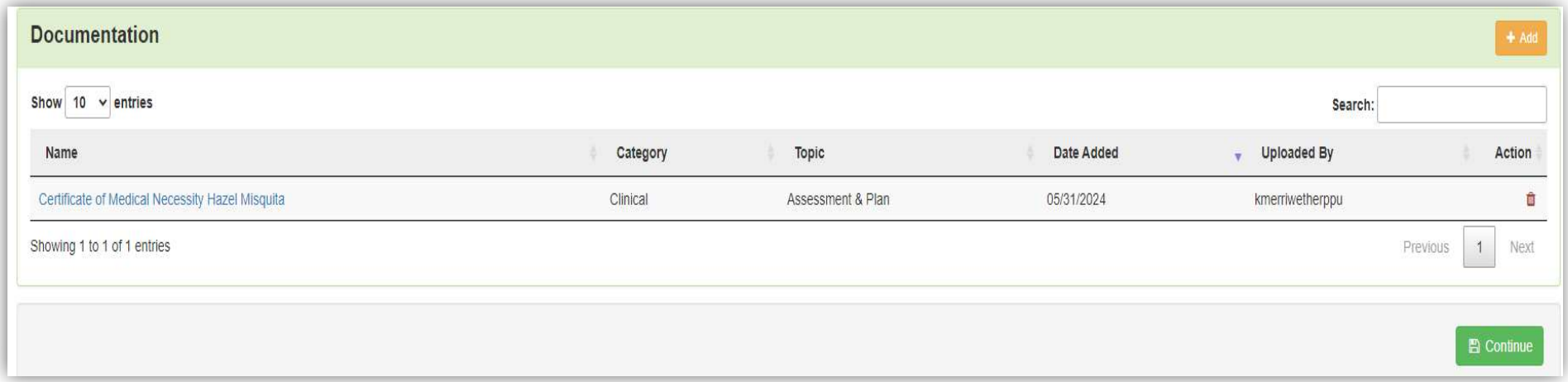
Submit will add the procedure to the review.
Submit and Add Another will allow you to submit the procedure to the review and re-open the window where you can search for another procedure
Enter as many procedures as needed.

Note: **Attach the correct modifier for all codes.**
Modifiers is a required field in Qualitrac.

Exception: **S3122** does not require a modifier

Completing your Review

- Once all the panels have been filled out, click Continue in the bottom right of the page to complete the review.



Documentation

Do's & Don'ts of Clinical Documentation

✅ Do	❌ Don't
Document **diagnosis + onset + clinical presentation**	Assume "diagnosis" alone proves necessity
Provide **labs, vitals, imaging, response to treatment**	Use vague statements like "patient doing well"
Show **why current level of care is required**	Leave out why lower level of care isn’t appropriate
Update records **daily** for inpatient/concurrent reviews	Submit outdated progress notes
Include **functional limitations or safety risks**	Forget to document why patient still needs care
Match documentation to **review criteria (InterQual)**	Submit generic info without criteria alignment

Required Documentation

- A signed physician's or specialist order for PDN or Certificate of Medical Necessity (CMN)
- A signed Plan of Care
- Beneficiary diagnosis
- Skilled teaching/instructions to be provided to family member/caregiver
- Treatment plan/physician orders specifying each skill to be performed including whether the service requires a registered nurse or licensed practical nurse.
- Expected duration of service
- Identification of any other home services, including the hours, days and times of these services.

All documentation must be dated and signed (electronic signatures are accepted).
All documentation must include 2 patient identifiers on each page

Request for Information

A Note about Timeframes

Provider Timelines

- Initial requests for PDN should be prior authorized.
- Retrospective requests will be reviewed for beneficiaries with retro-eligibility.
- Continued stay reviews must be submitted every 6 months prior to the end of the current certification period.

Provider Timeframes

- Providers have 10 business days to respond to a request for information (RFI).
- Providers should enter reviews for urgent or emergent admissions on the next business day after the admission.

The Telligen portal is available 24/7/365, except for scheduled maintenance days.

Request for Information

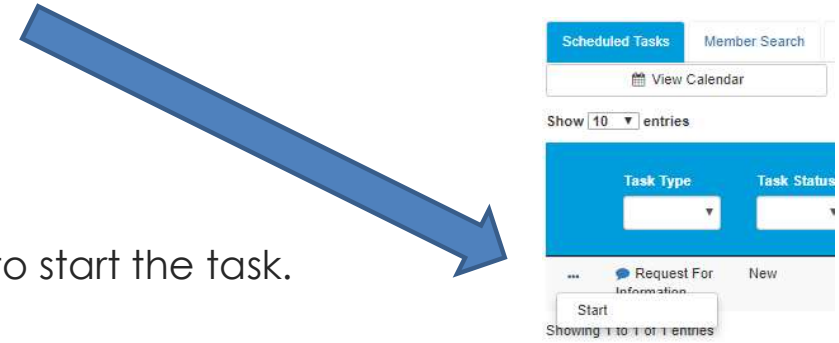
When a reviewer needs additional clinical documentation to make a determination, the submitter will be notified that additional Information is needed.

Notification Methods:

For portal users, you will receive an email notification of the request for more information
A task will populate in the Qualitrac system

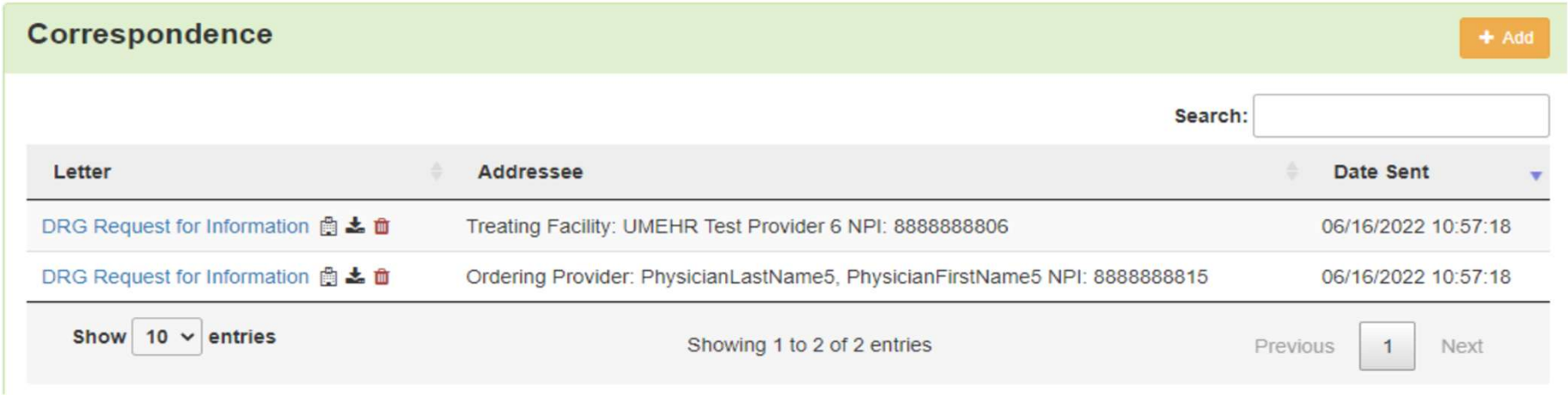
User steps:

Log into Qualitrac
Proceed to scheduled tasks
Click on the ellipsis to the left of the page, to start the task.



Request for Information

Scroll down the **summary page** of the review
Proceed to the correspondence section.
Click on the blue name of the letter to open it and see what information is being requested.



Request for Information

Scroll up to the **Documentation panel** to attach additional information.
Click on the Add button to attach additional clinical documentation to the review.



Request for Additional Information

- Once you **add all** necessary information, the system will trigger a task for the Reviewer

- Once you have added the additional information, the system will return you to the Scheduled tasks queue and the task will no longer be visible for the user.

- ****Do NOT start a new review** to submit additional clinical information that was requested. This will delay the response. Please follow the steps outlined when a Request for Information task is available in the task queue.

Submitting Change Request

What is a Change Request?

A **Change Request Form** is used to request **simple modifications** to a **previously approved** prior authorization (PA). Change Request forms must be within 90 days of the PA approval date listed in your decision letter. Change Request should be faxed 800-524-5710 or email: MSMedicaidUM@Telligen.com

It is **not** intended for:

- Reconsiderations or appeals of denied claim (including tech denials)
- Updates to claims that have already been paid

Change Requests for Increased Hours

- **Start Date Required**
  Clearly state the exact date the increased hours should begin
- **Specify Additional Hours**
  Indicate how many extra hours per day are needed for the remainder of the certification period
- **Updated Documentation**
  Submit an updated CMN signed by the physician reflecting the new total hours

Example of Change Requests for Increased Hours

Example: Change Request Form – Increased PDN Hours
Member Name: John Doe
Medicaid ID: 123456789
Date of Birth: 01/15/2016
Original Authorization:

Certification Period: 07/01/2025 – 12/31/2025

Approved Hours: 12 hours/day

Requested Change:

Start Date of Increase: 09/01/2025

New Hours Requested: 16 hours/day

Additional Hours Needed: 4 hours/day for the remainder of the certification period

Supporting Documentation Attached:

Updated Certificate of Medical Necessity (CMN) signed by Dr. Jane Smith on 08/20/2025, noting medical necessity for 16 hrs/day

Updated Plan of Care reflecting increased nursing support

Reason for Request:
Member's condition has worsened requiring additional overnight monitoring and skilled interventions.

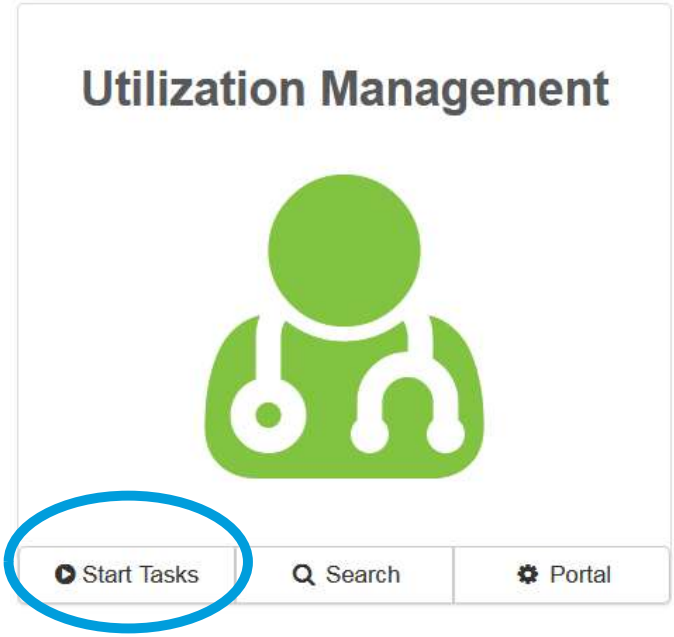
When to use a Change Request

Scenario	Is Change Request Appropriate?	Required Action	Notes
Update minor data entry errors	Yes	Submit Change Request Form	Cannot extend beyond current lock-in
Correct diagnosis code	Yes	Submit Change Request Form	Provide correct diagnosis with justification
Change NPI or place of service	Yes	Submit Change Request Form	MANUAL UPDATE REQUIRED: Ensure accuracy to avoid denial
Denied authorization	No	Submit Reconsideration Request	Use the Appeals process
More than 90 days since approval	No	Contact Telligen	MANUAL UPDATE REQUIRED: Changes not accepted after 90 days
Extend Dates of Service	No	Submit an extension request	Submit before current auth expires

Discharge Task

Discharge Information Task

- Providers will receive a Discharge Information Task.
- This task will be shown in the scheduled task queue with the task type of "Discharge Status."
  - If the member has not been discharged and is still in the facility, the task does not need to be started until the discharge occurs.
- If an extension of stay (CSR) is submitted, the task will be removed and a new task will be displayed once the Continue Stay Review has been completed.



Discharge Information

- **Discharge Documentation** The user will be required to enter the following three pieces of information:
    - indicate if the person is still in the facility
    - enter the actual Discharge Date
    - Enter the Discharge Disposition.

- **Diagnosis Panel Update**: The user can update the diagnosis of the member and indicate a Final Diagnosis by selecting the radio button under Final Diagnosis. It can stay the same as the original diagnosis.

- **Completing the Task**: Once all the information has been entered in the panels, the user can complete the process by clicking the "Close Case" button at the bottom of the page.

Requesting a Continued Stay Review

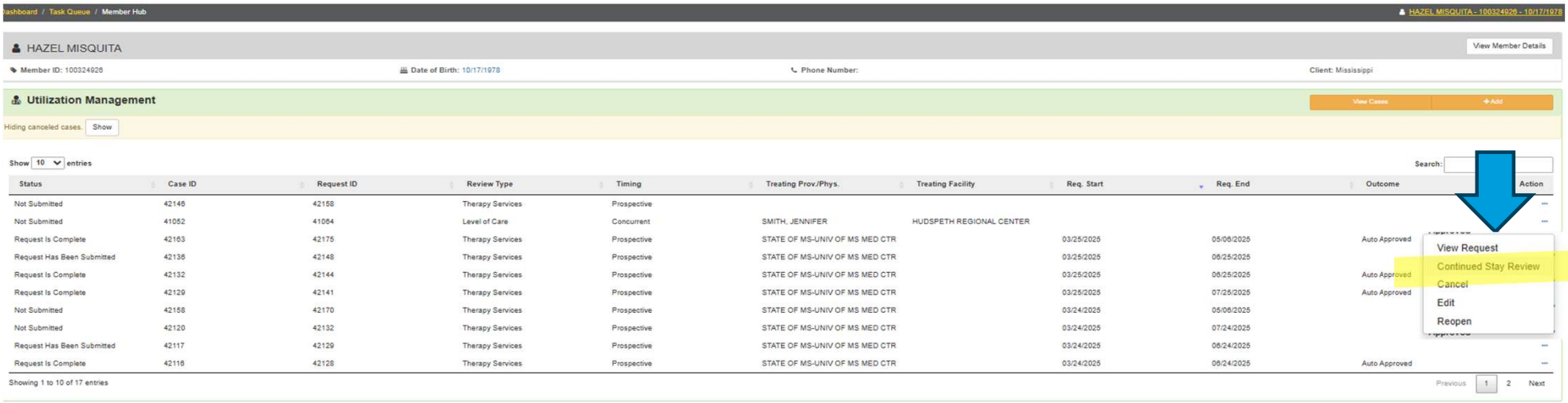
Continued Stay Reviews

- A **Continued Stay Review (CSR)** is a request submitted to **extend a patient's stay** in a healthcare facility beyond the initial approved authorization period. It ensures that extended care is **medically necessary** and meets the required **clinical criteria** for continued hospitalization

- **Why is a Continued Stay Review Needed?**
  - To ensure **continuity of care** for patients requiring **additional inpatient treatment**.
  - To provide **medical justification** for extended stays based on **clinical criteria** and **InterQual guidelines**.
  - To maintain compliance with **Mississippi Medicaid** regulations and avoid **claim denials** due to lack of prior approval

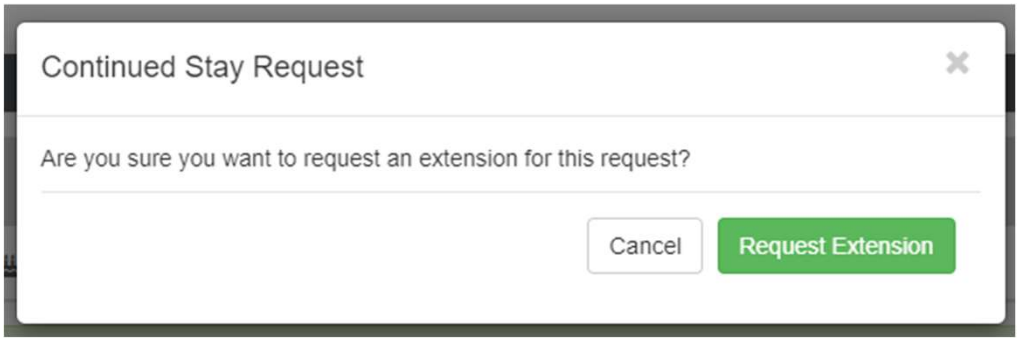
Request for Continued Stay

- From the Member Hub, under UM Panel, locate the case you would like to request an extension for DOS



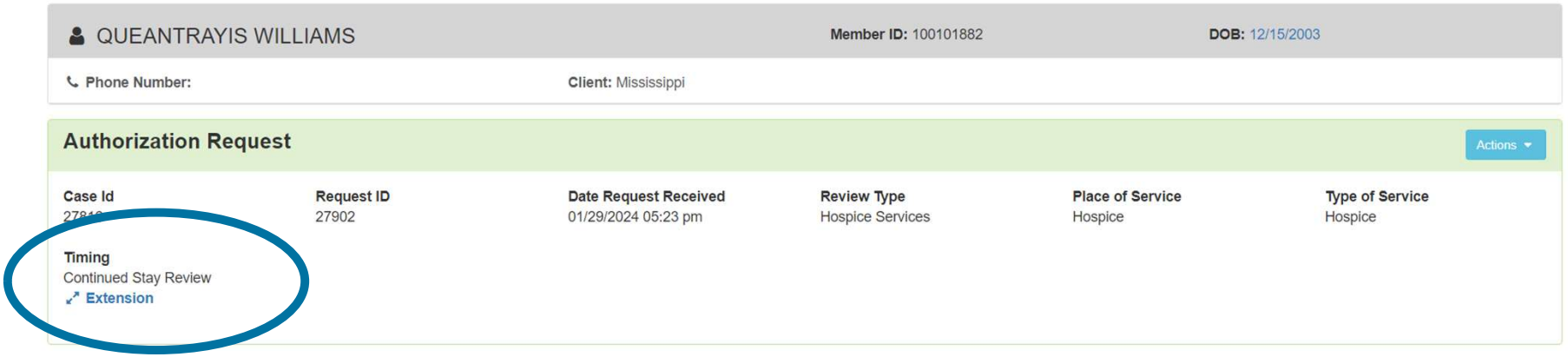
Continued Stay Review

- The system will validate that you want to request an extension
- Click the green button for **request extension**
- If this was done in error, click cancel



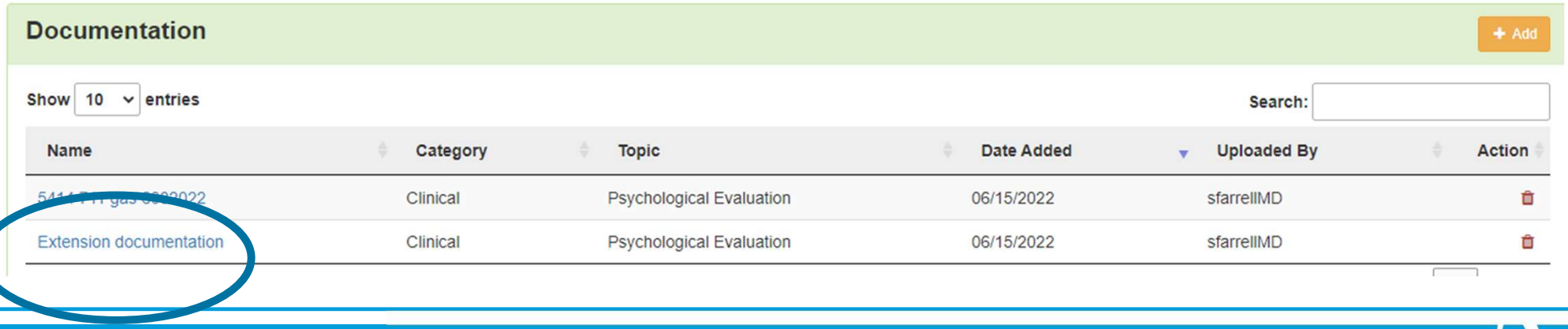
Continued Stay Review

- The system user will be directed to update and complete the extension request
- The timing section of the **Authorization Request panel** will indicate you are completing a continued stay review extension



Continued Stay Review

- The User will review all the panels and update appropriately
  - Update any new diagnosis to support the extension in the diagnosis panel
  - Provide supporting documentation in the Documentation Panel to indicate the need for an extension
  - Click **Continue**



Appeal Rights and Submission Process

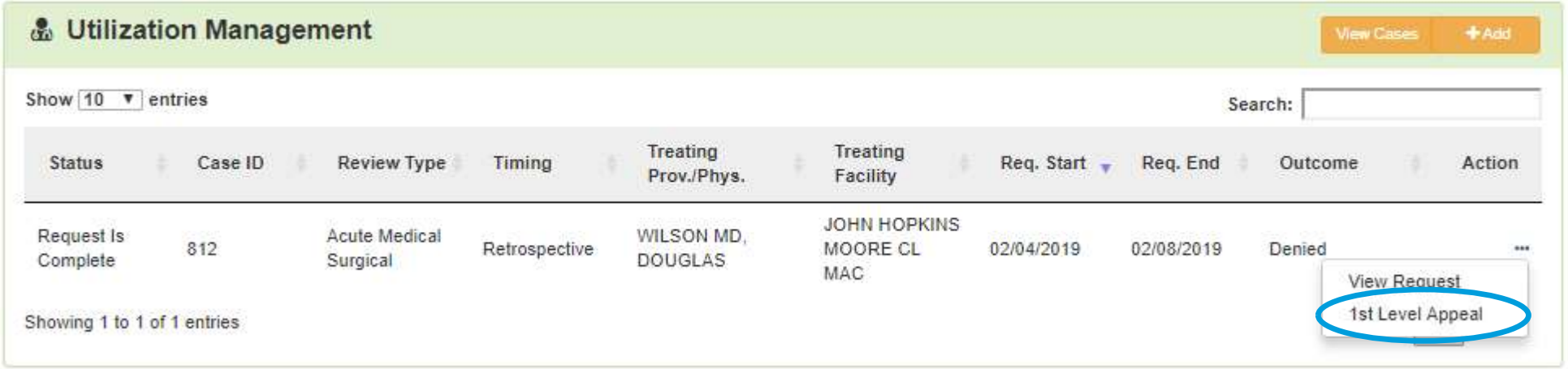
Appeal Rights & How to submit Appeal Levels

When a review has a determination of denied or partial denial, the provider can submit an appeal. The provider will have 30 calendar days from the date of outcome letter to submit the request.

- **1st level** – Submit a reconsideration request via Qualitrac
- **2nd level-** Request a Peer-to-Peer with a Telligen MD
- **3rd (final**) – Submit a written request for Administrative Appeal with DOM

Submitting a Reconsideration (1st Level Appeal)

- To submit a reconsideration for a denied review:
  - Go to the **UM panel** in the member hub
  - Click on the blue ellipsis within the denied case to open the action menu
  - Once there, select **1st Level Appeal** from the menu.



Appeal Rights & How to submit Appeal Levels

Appeal Level	Submission Method	Key Details Required	Submission
1st Level	Qualitrac Portal	Case # or Member ID + Upload additional documentation	Use Qualitrac
2nd Level	Peer-to-Peer (P2P)	Call or email with: Case #, physician info, contact #, and availability	1-855-625-7709 msmedicaidum@telligen.com
3rd Level	Written Administrative Appeal	Submit written request by mail (include case # and documentation)	Division of Medicaid Attn: Office of Appeals 550 High Street, Suite 1000 Jackson, MS 39201

Website Tour & Survey

Contact Us

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SURVEY

https://www.surveymonkey.com/r/NY3QPZJ